Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: KARAVEL SHOES 5525 BURNET ROAD #1 AUSTIN TX 78756-1603	MFDR Tracking #: M4-05-2406-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: TEXAS MUTUAL INSURANCE CO Box #: 54	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Rationale for Increased Reimbursement: "4/26/04 Received verbal authorization from Beth Robyn Christian and E. Villareal to dispense 2 pair of custom inserts (at $30.00 a pair) and one pair of orthopedic shoes." "10/5/4 spoke c Denise Curor-she said she would only pay another 74.65 on one insert she wants 'cost analysis' for inserts. Advised this cannot be done. With the cost of materials process & salary of c Red involved we offer the most cost effective insert in the area." [sic]

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Total Amount Sought - $505.70

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "It is the carrier's position that a fair and reasonable reimbursement has been made for the charge billed with code L3222 and fee schedule reimbursement for code L3060." "It is also this carrier's position the requester did not appeal the reimbursement for code L3222 before requesting dispute resolution. (Exhibit 2) TWCC Rule 133.304(k) states in part, "If the sender of the bill is dissatisfied with the insurance carrier on a medical bill, the sender may request that the carrier reconsider its action." "The Texas State Office of Hearings has upheld that 'reconsideration…is a required step before filing for Commission Dispute Resolution…" "Regarding code L3060, it remains this carrier's position that reimbursement was made per the fee schedule and no additional reimbursement is due. (Exhibit 3)" "This carrier reimbursed 125% of the DMEPOS fee schedule."

Principal Documentation:

1. DWC 60 Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
5/6/04	HCPCS code L3222	Not Applicable	$55.00	$0.00
	HCPCS code L3060 X 2	$38.09 X 2=$76.18 X 125% = $95.23 IC previously paid $149.30	$450.70	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on November 30, 2004. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 7, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
2. Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, requires that services not identified in a fee guideline shall be reimbursed at fair and reasonable rates.
3. Texas Labor Code §413.011 requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control.
4. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment.
5. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedure for medical fee dispute resolution.
6. Division rule at 28 TAC §133.304, effective July 15, 2000, 25 TexReg 2115, requires the insurance carrier to develop and consistently apply a methodology to determine fair and reasonable reimbursement.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 6/8/2004

   - 40-The charge for the services exceeds an amount which would appear reasonable when compared to the charges of other providers in the same geographic area.
   - YM-The reimbursement for the service rendered has been determined to be fair and reasonable based on billing and payment research and is in accordance with Labor Code 413.011(D).
   - 01-The charge for the procedure exceeds the amount indicated in the fee schedule.

   Explanation of benefits dated 6/16/2004 for HCPCS code L3060

   - YO-Reimbursement was reduced or denied after reconsideration of treatment/service billed.

   Explanation of benefits dated 11/3/2004 for HCPCS code L3060

   - YS-Supplemental Payment.

Issues

1. Was the dispute filed in accordance with Division rule at 28 TAC §133.304?
2. What is the applicable rule for reimbursement?
3. Did the requestor support the position that additional reimbursement is due for HCPCS codes L3222 and L3060?
4. Is the requestor entitled to additional reimbursement?

Findings

1. Division rule at 28 TAC §133.304(k)(1)(A) requires that if a health care provider "…is dissatisfied with the insurance carrier's final action on a medical bill, the sender may request that the insurance carrier reconsider its action. The sender shall submit… (1) a copy of the medical bill that the health care provider is requesting the insurance carrier to reconsider, (A) clearly marked with the statement 'REQUEST FOR RECONSIDERATION." The respondent states in the position summary that "It is also this carrier's position the requester did not appeal the reimbursement for code L3222 before requesting dispute resolution." A review of the submitted documentation finds that the medical bill dated 11-11-04, lists both HCPCS codes L3222 and L3060, and is clearly marked "Request for Reconsideration." Therefore, the requestor did submit HCPCS code L3222 for reconsideration.

   Division rule at 28 TAC §133.304(m) states "The sender of a medical bill may request medical dispute resolution in accordance with §133.305 of this title (relating to Medical Dispute Resolution) if the sender of a medical bill has requested reconsideration in accordance with this section and: (1) after reconsideration, the sender is still dissatisfied with the insurance carrier's action on the medical bill; or (2) the sender has not received the insurance carrier's

response to the request for reconsideration by the 28th day after the date the request for reconsideration was sent to the insurance carrier." The requestor did not submit a reconsideration EOB for HCPCS code L3222. The request for reconsideration bill is dated 11-11-04. The request for medical fee dispute resolution was submitted on 11-30-04, nineteen days after the bill was sent for reconsideration. The requestor did not submit the request for dispute resolution in accordance with Division rule at 28 TAC §133.304(m).

2. Division rule at 28 TAC §134.1 requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

   Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.

   Division rule at 28 TAC §134.202(c)(2) states "for Healthcare Common Procedure Coding System (HCPCS) Level II codes, A, E,J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection."

   - HCPCS code L3222 is described as "Orthopedic footwear, mens shoe, hightop, depth inlay, each." Neither the DMEPOS fee schedule nor the Texas Medicaid Fee Schedule has set a fee for HCPCS code L3222.
   - HCPCS code L3060 is described as "Foot, arch support, removable, premolded, longitudinal/metatarsal, each." Per DMEPOS, HCPCS code L3060 has a fee of $38.09.

   Division rule at 28 TAC §134.202(c)(6) states "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." The Division finds that HCPCS codes L3222 does not have an established relative value and the insurance carrier did not submit documentation to support that the carrier has assigned a relative value.

   Division rule at 28 TAC §134.202(d) states "In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)."

   Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated and/or contracted between the provider and carrier for the disputed HCPCS code L3222 therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate in accordance with Division rule at 28 TAC §134.1.

3. Division rule at 28 TAC §133.307(g)(3)(D) requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:

   - The requestor's rationale for increased reimbursement taken from *Table of Disputed Services* states that "4/26/04 Received verbal authorization from Beth Robyn Christian and E. Villareal to dispense 2 pair of custom inserts (at $30.00 a pair) and one pair of orthopedic shoes." "10/5/4 spoke c Denise Curor-she said she would only pay another 74.65 on one insert she wants 'cost analysis' for inserts. Advised this cannot be done. With the cost of materials process & salary of c Red involved we offer the most cost effective insert in the area." [sic]
   - The requestor did not submit documentation to support the rationale that $275.00 was a fair and reasonable rate of reimbursement for HCPCS code L3222.
   - The requestor has not articulated a methodology under which fair and reasonable reimbursement should be calculated.
   - The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement.
   - The requestor does not discuss or explain how payment of the requested amount would ensure the quality of medical care, achieve effective medical cost control, provide for payment that is not in excess of a fee charged for similar treatment of an injured individual of an equivalent standard of living, consider the increased security of payment, or otherwise satisfy the requirements of Texas Labor Code §413.011(d) or Division rule at 28 TAC §134.1.

The request for additional reimbursement for HCPCS code L3222 is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended for HCPCS code L3222.

4. Reimbursement will therefore be calculated according to Division rule at 28 TAC §134.202(c)(2), for HCPCS codes L3060.

   - Per DMEPOS, HCPCS code L3060 has a MAR of $38.09. On the disputed date of service the requestor billed for 2 units. $38.09 X 2 = $76.18. This amount multiplied by 125% = $95.23. The insurance carrier paid $149.30. As a result the amount ordered is $0.00.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. For the reasons stated above, the division finds that the requestor has failed to establish that additional reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services involved in this dispute.

		June 25, 2010
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.